837 Health Care Claims/Encounters Institutional

Companion Transaction Specifications

Version 1.0

Disclaimer

This Companion Document is intended to be a technical document describing the specific technical and procedural requirements for interfaces between DES and its trading partners. It does not supersede either health plan contracts or the specific procedure manuals for various operational processes. If there are conflicts between this document and either the provider contracts or operational procedure manuals, the contract or procedure manual will prevail.

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837 Institutional

Loop ID	Segment ID	Element ID	Element Name	Valid Values	Definition/Format CMDP	Usage
N/A	REF	02	Transmission Type Code		Pilot Testing: 004010X096DA1 Production: 004010X096A1	Required
1000A	NM1	NM108	Identification Code Qualifier	46	Electronic Transmitter Identification	Required
1000A	NM1	NM109	Submitter Identifier		CMDP Assigned Trading Partner ID	Required
1000B	NM1	NM103	Receiver Name		CMDP	Required
1000B	NM1	NM108	Identification Code Qualifier	46	Electronic Transmitter Identification Number (ETIN)	Required
1000B	NM1	NM109	Receiver Primary Identifier		C866004791	Required
2010AA	NM1	NM108	Identification Code Qualifier	24 or 34	Federal Taxpayer Identification Number	24 or 34
2010AA	NM1	NM109	Billing Provider Identifier		Billing Provider's Federal Taxpayer Identification Number	
2010AA	REF	REF01	Reference Identification Qualifier	1D B3	Indicate 1D for Medicaid Provider Number	1D B3
2010AA	REF	REF02	Billing Provider Additional Identifier		Billing Provider's AHCCCS ID	
2010AB	NM1	NM108	Identification Code Qualifier	24 or 34	Federal Taxpayer Identification Number	Required
2010AB	NM1	NM109	Pay To Provider Identifier		Pay To Provider's Federal Taxpayer Identification Number Use Loop 2010 AB only when Pay To Provider is different from Billing Provider.	Required if applicable
2010AB	REF	REF01	Reference Identification Qualifier	1D B3	Indicate 1D for Medicaid Provider Number	Required if applicable
2010AB	REF	REF02	Pay To Provider Additional Identifier		Pay To Provider's AHCCCS ID	Required if applicable
2000B	SBR	SBR02	Individual Relationship Code	18	Self	Required

Loop ID	Segment ID	Element ID	Element Name	Valid Values	Definition/Format CMDP	Usage
2000B	SBR	SBR09	Claim Filing Indicator Code	MC	Indicate MC for Medicaid	Required
2010BA	NM1	NM108	Identification Code Qualifier	MI	Member Identification Number	Required
2010BA	NM1	NM109	Subscriber Primary Identifier		Member's ID (As it appears on CMDP Identification Card)	Required
2010BB	NM1	NM103	Payer Name		CMDP	Required
2010BB	NM1	NM108	Identification Code Qualifier	PI	Payer Identification	Required
2010BB	NM1	NM109	Payer Identifier		C866004791	Required
2300	CLM	CLM01	Patient Account Number		This is the Patient Account Number used by the provider that performed the service. For HIPAA, the maximum length of the field is 20 characters.	Required
2300	CLM	CLM05-1	Facility Type Code		Place of Service can be submitted at the claim level. Place of Service Codes submitted at the claim level apply to all service lines unless overridden by a different Place of Service at the line level (SV105 in Loop 2400).	Required
2300	CLM	CLM05-3	Claim Frequency Code		The Claim Frequency Code is the third character of the UB Type of Bill field on institutional claims	Required
2300	CLM	CLM18	Explanation of Benefits Indicator		CMDP does not provide paper EOBs and will not respond to any value in this required institutional element. Recommend N in CLM 18	Required
2300	DTP	DTP01	Date Time Qualifier	096	Only the discharge Hour is present in this segment. The discharge date on a discharge claim is the Through Date in the Statement Date DTP segment when the claim frequency code (CLM05-03) indicates a	Required if applicable

Loop ID	Segment ID	Element ID	Element Name	Valid Values	Definition/Format CMDP	Usage
					discharge.	
2300	DTP	DTP02	Date Time Period Format Qualifier	TM	Time expressed in format HHMM	Required if applicable
2300	DTP	DTP03	Discharge Hour		Discharge Hour	Required if applicable
2300	DTP	DTP01	Statement Date or Range Qualifier	434	The Statement Date can be either a single date or a date range. Normally, it is a single date on outpatient claims and a date range on inpatient claims.	Required
2300	DTP	DTP01	Date/Hour Qualifier	435	Admission	Required
2300	DTP	DTP02	Date/Time Period Format Qualifier	D8	Date and time expressed in format CCYYMMDDHHMM.	Required
2300	DTP	DTP03	Admission Date and Time		Indicate Admission Date and Time	Required
2300	REF	REF01	Reference Identification Qualifier	F8	Original Reference Number This REF Segment is required if a claim voids or replaces another claim.	
2300	REF	REF02	Claim Original Reference Number		For replacement and void claims (CLM05-3 = “7” or “8”), the AHCCCS Claim Reference Number (CRN) of the prior claim being replaced or voided.	
2300	REF	REF01	Reference Identification Qualifier	G1	Prior Authorization Number	Required if applicable
2300	REF	REF02	Prior Authorization Number		The Prior Authorization Number	Required if applicable
2300	HI	HI01-1	Code List Qualifier Code	BK	Principal Diagnosis Required on all institutional claims	Required
2300	HI	HI01-1	Code List Qualifier Code	BF	Diagnosis These are diagnoses in addition to the required Principal Diagnosis Codes in a previous segment.	Required if applicable
2300	HI	HI01-1	Code List Qualifier Code	BR	International Classification of Diseases Clinical Modification (ICD-	Required if applicable

Loop ID	Segment ID	Element ID	Element Name	Valid Values	Definition/Format CMDP	Usage
					9-CM) Principal Procedure CMDP expects ICDC-9 Procedure Codes to be submitted in the claim-level 2300 Loop for impatient services only . HCPCS outpatient procedures are submitted at the service line level in the 2400 Loop of the Institutional 837.	
2300	HI	HI01-1	Code List Qualifier Code	BQ	International Classification of Diseases Clinical Modification (ICD-9-CM) Procedure CMDP expects ICD-9-CM Procedure Codes to be used for inpatient procedures and for HCPCS Codes to be used at the service line level for outpatient procedures.	Required if applicable
2300	HI	HI01-1	Code List Qualifier Code	BI	Occurrence Span .	Required if applicable
2300	HI	HI01-1	Code List Qualifier Code	BH	Occurrence	Required if applicable
2300	HI	HI01-1	Code List Qualifier Code	BE	Value	Required if applicable
2300	HI	HI01-1	Code List Qualifier Code	BG	Condition	Required if applicable
2300	HI	HI01-1	Code List Qualifier Code	TC	Treatment Codes	Required if applicable
2300	QTY	QTY01	Quantity Qualifier	CA	Covered – Actual	Required
2300	QTY	QTY02	Claim Days Count		The number of covered actual days	Required
2300	QTY	QTY03-1	Unit or Basis for Measurement Code	DA	Days Use whole numbers without decimal points.	Required
2310A	NM1	NM108	Identification Code Qualifier	24 or 34	Employer's Identification Number Social Security Number	Required if applicable

Loop ID	Segment ID	Element ID	Element Name	Valid Values	Definition/Format CMDP	Usage
2310A	NM1	NM109	Attending Physician Primary Identifier		The attending physician's Federal Tax ID or Social Security Number	Required if applicable
2310A	REF	REF01	Reference Identification Qualifier	1D B3	Indicate 1D for Medicaid Provider Number If an attending physician is specified then this REF segment will need to be provided	Required if applicable
2310A	REF	REF02	Attending Physician Secondary Identifier		Provider's AHCCCS ID	
2310E	NM1	NM108	Identification Code Qualifier	24	Employer's Identification Number Submit the 2310E Laboratory or Facility Loop only if the ID of the facility is different from the ID of the billing provider in Loop 2010AA.	Required if applicable
2310E	NM1	NM109	Service Facility Primary Identifier		The facility's Federal Tax ID	Required if applicable
2310E	REF	REF01	Reference Identification Qualifier	1D B3	Indicate 1D for Medicaid Provider Number If a service facility is specified then this REF segment will need to be provided	Required if applicable
2310E	REF	REF02	Laboratory or Facility Secondary Identifier		Provider's AHCCCS ID	Required if applicable
2310A	NM1	NM108	Identification Code Qualifier	24 34	Employer's Identification Number Social Security Number Use the 2310A Loop when a referring provider is present at the claim level Please note that for CMDP the referring provider should be indicated in the claim level and not at the claim line level	Required if applicable
2310A	NM1	NM109	Referring Provider Identifier		The referring provider's Federal Tax ID or Social Security Number.	Required if applicable
2310A	REF	REF01	Reference Identification Qualifier	1D B3	Indicate 1D for Medicaid Provider Number If a referring physician is specified	Required if applicable

Loop ID	Segment ID	Element ID	Element Name	Valid Values	Definition/Format CMDP	Usage
					then this REF segment will need to be provided	
2310A	REF	REF02	Referring Provider Secondary Identifier		Provider's AHCCCS ID	Required if applicable
2320	SBR	SBR01	Payer Responsibility Sequence Number Code	P S T	Primary Secondary Tertiary Other carrier Loop 2320 can occur up to ten times for up to ten payers other than DES.	Required if applicable
2320	SBR	SBR03	Insured Group or Policy Number		A Group or Policy Number associated with the other coverage.	Required if applicable
2320	SBR	SBR04	Other Insured Group Name		A Group or Policy Name associated with SBR03	Required if applicable
2400	LX	LX01	Assigned Number	1-999	The 837 I supports up to 999 lines	Required
2400	SV21	SV201-	Service Line Revenue Code		This is the Revenue Code used to bill inpatient services. Not expected on outpatient claims	Required if applicable
2400	SV2	SV202-1	Product or Service ID Qualifier		Claim submitters use HCPCS Procedure Codes (Qualifier "HC") in this segment for outpatient institutional services. One or more HCPCS Procedure Code is required for all outpatient institutional claims	Required if applicable